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*Providing Insights that Contribute
to Better Health Policy*

April 10, 2003

The Honorable Max Baucus
Committee on Finance
United States Senate
Washington, DC 20510-6200

Dear Senator:

I am pleased to answer the questions that you posed to me in your letter of April 4 concerning the potential for private plans in the Medicare program to realize lower costs.

The Center for Studying Health System Change has been monitoring and analyzing health care markets since 1995. We visit a representative sample of 12 communities every two years for in-depth interviews with leaders of the major elements of local health systems. These site visits complement our surveys of households and physicians. The period in which we have studied these markets encompassed both the expansion of managed care and its subsequent transformation in response to a backlash by consumers and physicians.

1) What is the available evidence of private health plans' ability to negotiate lower provider payment rates than fee-for-service Medicare currently pays? Is there any evidence of excess capacity in the health care system that would enable private health plans to negotiate lower rates than Medicare fee-for-service?

In most areas of the country, payment rates for hospitals and physicians that are negotiated by private plans are higher than those paid by the Medicare fee-for-service (FFS) program. In our site visits, we routinely ask managed care plans how much they pay physicians. Since virtually all of them use the Medicare fee schedule as a benchmark, they usually answer the question in terms of a percentage of Medicare rates. In our 2000-2001 site visits, we found that private plans in 8 communities paid higher rates than Medicare while plans in 4 communities paid less. During our current round of site visits, which is mostly complete, 2 communities changed from private plans paying less than Medicare to more while none moved in the opposite direction. We have witnessed this trend of rates paid by private plans increasing relative to Medicare payment rates over a number of rounds of site visits.

Quantitative data analyzed by the Medicare Payment Advisory Commission (MedPAC) show higher payment rates in private health insurance (virtually all of which is managed care) for both physicians and hospitals. An analysis of claims data by Hogan conducted for MedPAC estimates that private insurers paid 25 percent higher rates than Medicare to physicians in 2001. MedPAC staff analysis of the American Hospital Association's Annual Survey shows that private insurers paid 14 percent higher rates for hospital care than Medicare in 2001 (*Report to Congress* March 2003).

An important factor behind this trend of payment rates by private insurers increasing in relation to Medicare rates is a trend of tightening capacity. Our 2000-2001 round of site visits found much greater pressures on hospital capacity. Many hospital executives indicated that lack of excess capacity had given them the leverage to decline managed care contracts with unattractive payment rates (see *Health Plan-Provider Showdowns on the Rise*, HSC Issue Brief No. 40, June 2001). HSC's physician survey has shown a strong trend of increasingly tight physician capacity. Waiting times for appointments are increasing and fewer physicians are accepting all new patients. These trends are similar for Medicare and privately insured patients (see *Growing Physician Access Problems Complicate Medicare Payment Debate*, HSC Issue Brief No. 55, September 2002).

2) How do private plans' ability to negotiate lower rates vary across the country?

For physician payment, we see large variation in payment rates for private plans relative to Medicare FFS across the 12 communities we track. In our 2000-2001 site visits, we found that in Miami, northern New Jersey and Orange County, California, private insurers' physician payment rates relative to Medicare are relatively low compared with other communities. For example, in Miami, private payments range from 80 to 108 percent of Medicare physician payments. In northern New Jersey, private rates ranged from 95 to 105 percent of Medicare payments. In contrast, Boston, Cleveland, Greenville, Little Rock and Seattle have private rates that are much higher than Medicare. For example, private payments in Little Rock range from 120 to 180 percent of Medicare physician payments and from 100 to 150 percent in Boston. This pattern of relative differences across markets has remained stable over time. Those markets that are typically more generous than Medicare have maintained these higher rates over the last 8 years of our study. Similarly, the communities with the lowest rates have consistently paid lower rates than other communities.

This pattern of variation in the ratio of private payments to Medicare payments is seen in hospitals as well. Interviews with insurers in the California market indicated that the Sacramento area has payment rates that are much higher than in San Francisco, which in turn are much higher than those in Los Angeles.

The ratio of private insurance payment rates to Medicare FFS payment rates is likely to be particularly unfavorable in rural areas. Although HSC does not collect this type of data for rural areas, managed care industry sources have reported that lack of competition among providers in rural areas results in little ability of private insurers to obtain discounts from charges.

This variation in payment ratios across communities suggests that there are likely to be some areas in which private plans can negotiate rates that are lower than Medicare FFS, but in most areas the opposite is true. But the trends are towards fewer areas in which the private plans have lower rates than Medicare FFS. Consequently, the presence in a few communities of PPOs that appear to have potential for lower costs than Medicare FFS is not an indication that this could happen in most areas.

3) What is the current trend of preferred provider organizations' (PPOs') ability to control and reduce their enrollees' health care utilization of hospital and physician services?

Our site visits show a broad decline in recent years in efforts by all managed care plans to reduce their enrollees' health care utilization. This is a reflection of the backlash against the restrictions of managed care. Indeed, this has been augmented by enrollment changes away from HMOs towards PPOs, as consumers seek broader choice of provider as well as fewer administrative controls. PPOs are the choice for those who are willing to spend more for health care in order to have less interference in their choice of provider and use of care.

Today, PPOs are engaged in few activities to manage care. Their main cost containment focus is on obtaining discounted rates. Their broader provider networks and their enrollees' ability to go out of network for some of their care makes it much more difficult for them than for HMOs to attempt to manage the utilization. For example, they cannot make physicians accountable for a patient's care when there is no requirement that patients see a single primary care provider as their initial point of contact in the health care system. An implication of this is that Medicare PPOs will inevitably be less successful in managing utilization of services than Medicare HMOs. Indeed, in employment-based insurance today, the PPO is often looked to by employers as a preferred platform to pursue a "consumer driven" approach to health care involving substantial patient cost sharing.

I would be pleased to be of further assistance to you and the Committee on these and related issues around reform of the Medicare program.

Sincerely Yours,

A handwritten signature in cursive script, reading "Paul B. Ginsburg". The ink is dark and the signature is fluid, with a long, sweeping underline.

Paul B. Ginsburg